

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33681

State File No. _____

Registrar's No. 9410

FILED NOV 1 1943
Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CITY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME RICHARD WYNN

3. (b) If veteran, name war NO. 3. (c) Social Security No. 493-10-523

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JANUARY 26 1904
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
39 8 29 hr. min.

9. Birthplace ST. LOUIS, MO.
(City, town, or county) (State or foreign country)

10. Usual occupation DEPUTY SHERIFF

11. Industry or business _____

12. Name PATRICK WYNN

13. Birthplace IRELAND
(City, town, or county) (State or foreign country)

14. Maiden name DELIA CORCORAN

15. Birthplace IRELAND
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Peter J. Wynn

(b) Address 5523 Tennessee Av.

17. (a) BURIAL (b) Date thereof Oct. 28-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director E. J. Schur

(b) Address 3125 Lafayette St.

19. (a) OCT 28 1943 (b) J. F. [Signature]
(Date received from Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 3640 RUTGER ST.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 25
year 1943 hour 5 minute 18 p.m.

21. I hereby certify that I attended the deceased from 2-14-42
to 10-20-43
that I last saw him alive on 10-20-43
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Embolic Artery

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)

(e) Means of injury _____

Signature F. V. [Signature] (M. D. or other)

Address 2767 [Signature] Date signed 10/26/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Joe B. Vollmer

Licensed Embalmer No. *41014*

P. O. Address.....

St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.